



TEXAS
Department of
State Health Services

Regulatory Licensing Unit EMS Certification & Licensing Group

Volunteer to Paid EMS Status Change

All information given on this application is considered public record, with the exception of social security number*.

If you applied for EMS certification/licensure as a volunteer and are now receiving payment for providing EMS services, you must pay a prorated fee to the department based on the number of years remaining in your certification/licensure period when employment begins. Submit completed form with check or money order payable to Texas

Dept of State Health Services. Mail to:

Section 1 – Personnel Data

TYPE OR PRINT IN BLACK INK

For DSHS Use Only
ZZ100-160

Receipt # _____
Date _____
Amount _____

Dept of State Health Services
ATTN: ZZ100-160 EMS
1100 West 49th Street
Austin, TX 78756-3199

Print Last Name	First Name	Middle Name	SS** or Texas EMS ID #
Mailing Address: Street, Apt Number or PO Box		City	State Zip
()	()		
Home Phone (area code)	Business Phone (area code)	Date of Birth (MM/DD/YY)	
*Disclosure of your social security number is voluntary. We recommend you provide your social security number to be used as a unique identifier to prevent confusion among applicants with similar or same name.			
I am or plan to receive payment for EMS services under the following level(s):			
<input type="checkbox"/> ECA	<input type="checkbox"/> EMT	<input type="checkbox"/> EMT-I	<input type="checkbox"/> EMT-P
<input type="checkbox"/> Lic-P	<input type="checkbox"/> Coordinator	<input type="checkbox"/> EMS Instructor	<input type="checkbox"/> EMS Information Operator Instructor

Section 2 – EMS Texas Employment Information

List Texas licensed EMS firms or First Responder Organizations for which you work/volunteer, use additional sheets if needed:			
Name of Texas firm	Address	City, State, Zip	Volunteer or Paid**
_____	_____	_____	_____
_____	_____	_____	_____

Section 3 – Fee

Use the following chart to determine the fee you owe. Your fee is based on the number of years remaining in your certification/licensure period when employment begins. Any portion of a year counts as a full year. Fees are not refundable or transferable. Make check or money order payable to Texas Dept of Health.		
ECA or EMT levels: <input type="checkbox"/> 48 – 35 months remaining: \$60 <input type="checkbox"/> 36 – 23 months remaining: \$45 <input type="checkbox"/> 24 – 13 months remaining: \$30 <input type="checkbox"/> 12 – 1 months remaining: \$15	EMT-I or Paramedic levels: <input type="checkbox"/> 48 – 35 months remaining: \$90 <input type="checkbox"/> 36 – 23 months remaining: \$67.50 <input type="checkbox"/> 24 – 13 months remaining: \$45 <input type="checkbox"/> 12 – 1 months remaining: \$22.50	Paramedic Licensure level: <input type="checkbox"/> 48 – 35 months remaining: \$120 <input type="checkbox"/> 36 – 23 months remaining: \$90 <input type="checkbox"/> 24 – 13 months remaining: \$60 <input type="checkbox"/> 12 – 1 months remaining: \$30
EMS Coordinator level: <input type="checkbox"/> 24 – 13 months remaining: \$60 <input type="checkbox"/> 12 – 1 months remaining: \$30	EMS Instructor level: <input type="checkbox"/> 24 – 13 months remaining: \$30 <input type="checkbox"/> 12 – 1 months remaining: \$15	EMS Info Operator Instructor level: <input type="checkbox"/> 24 – 13 months remaining: \$60 <input type="checkbox"/> 12 – 1 months remaining: \$30

Section 4 – Signature and Date

I hereby affirm and declare that all information submitted on this form is true and correct. I understand that false statements or information on this application may be considered as sufficient cause for denial of certification or decertification.	
Signature of Applicant: _____	Date: _____

PRIVACY NOTIFICATION:

With few exceptions, you have the right to request and be informed about information that the State of Texas collect about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023 and 559.004)

Because of different budget numbers, you must make separate checks for your certification application and for the magazine. Include both checks with your application packet and mail to: Texas Dept. of State Health Services, Attn: ZZ100-008 EMS, 1100 West 49th Street, Austin, TX 78756-3199. Or for faster magazine service, mail subscription form with magazine check separately to: DSHS-EMS, PO Box 149200, Austin, TX 78714-9200.

**For DSHS Use Only
ZZ100-008**

Receipt # _____
Date _____
Amount _____

Texas EMS Magazine

Subscription Form

\$25 for 2 years

\$45 for 4 years

Your point of contact with the agency that regulates Texas EMS – taking state and national EMS issues and answers to emergency medical services professional serving in every capacity across Texas.

Amount Enclosed \$ _____ for 2 or 4 (circle one) year subscription
ZZ100-008

____ New subscription

____ Renewal subscription

Fill in name and address and mail along with payment.

Please enter my subscription (please print)

Name _____

Address _____

_____ Zip _____

Make check or money order payable to:
Texas Department of State Health Services – ZZ100-008
(Please write magazine budget number ZZ100-008 on check)

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